Eastern Sun Healing, LLC

Massage Client Intake Form

Name: _____ Date of Birth: _____

Address: _____ Occupation: _____

City: _____ State: _____ Zip: _____

Phone: _____

Email: _____

Emergency Contact

Name: _____

Phone: _____

Health History

Are you currently under the care of a
Health Care Practitioner? ☐ Yes ☐ No

If yes, Name: _____ Phone: _____

Do I have permission to contact your doctor? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No If yes, what: _____

_____

Are you taking any medications? ☐ Yes ☐ No If yes, what: _____

_____

Recent Surgeries: _____

Recent Accidents: _____

Major Illnesses: _____

Please circle any symptoms or problems listed that you are currently experiencing or have experienced. Having this information helps me to treat you more effectively and efficiently.

Skin disease	Headaches	Insomnia	Allergies	Arthritis	Digestive problems
Communicable disease	Elimination problems	Kidney disease	Heart problems	Back problems	Ulcers
High/Low blood pressure	Joint problems	Diabetes	Blood Clots	Torn cartilage	HIV/AIDS
Varicose veins	Fractures	Cancer			

Have you ever received Professional Massage or other body work? ☐ Yes ☐ No

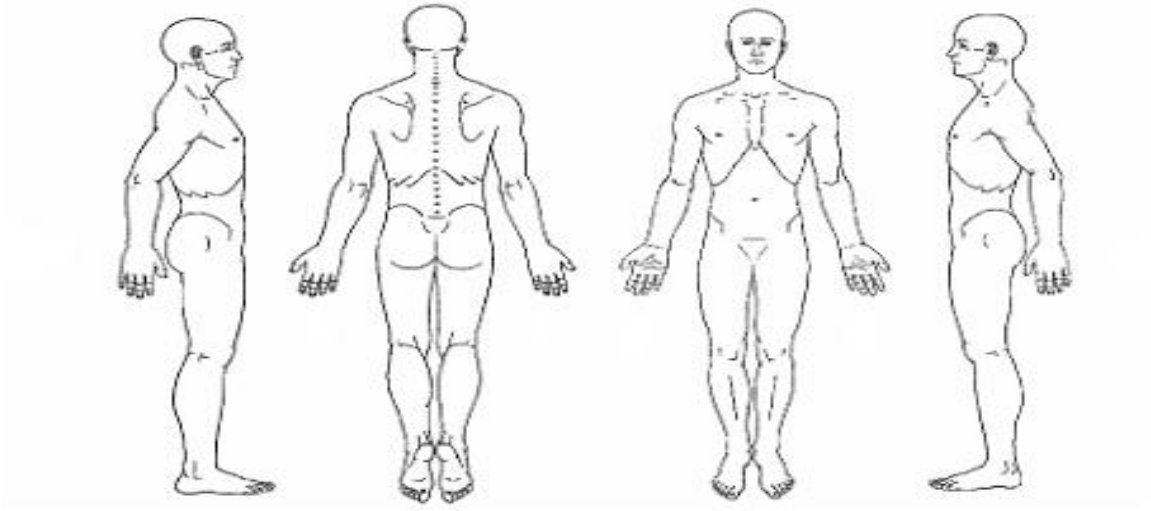
What are your expectations for this visit?

☐ Injury Treatment ☐ Stress Relief ☐ Other: _____

List stress reduction and exercise activities: _____

_____

What areas of the body are you experiencing pain or discomfort and would like worked for today's visit? (*Please circle the places that are currently hurting or bothering you.)*



When are these symptoms the worst?_____

_____

When are they the least?_____

_____

Eastern Sun Healing, LLC

Disclosure and Policy Information

Disclosure Statement

I have listed all my known medical conditions and physical limitations and will inform the massage practitioner of any change in my physical health between sessions. I am responsible for consulting a qualified primary care provider for any physical ailment that I may have. I understand that the massage practitioner must be aware of, any and all existing physical conditions in order to provide appropriate massage. I further understand that a massage therapist neither diagnoses nor prescribes for illness, disease, or any adjustments. I know that massage is for therapeutic purposes and any sexual conduct will end the massage immediately. I agree to communicate with my practitioner any time I feel like my well being is being compromised.

Privacy Policy

Eastern Sun Healing is required by law to protect the privacy of your health information.
Eastern Sun healing uses your personal information primarily for patient treatment and obtaining payment for treatment and evaluating quality care we provide.

You, the patient, have the right to obtain a copy of your health information at anytime. You have the right to request that we correct any inaccurate or incomplete information in your records.

Medical Release of Records

I hereby authorize the release of my medical records for the purpose of helping to resolve claims and payment issues for my medical bills incurred in this office.

I hereby authorize the insurance company or attorney to remit payment directly to this office. I hereby certify that I have read and understand that my medical information is private and allow Eastern Sun Healing to have access to it.

Cancellation Policy

I agree to give 24 hours notice of cancellation. If 24 hour notice is not given, I am responsible for a $50.00 fee; if I am receiving an Ayurvedic treatment I agree to pay for the total treatment respecting the massage therapists scheduled time, and the cost of materials it takes for the Ayurvedic treatments.

I hereby certify that I have read and understand that my medical information is private and allow Eastern Sun Healing to have access to it.

Signature: _____ Date: _____